SMU | Dedman School of Law

SMU Law Review

Volume 46 | Issue 2 Article 5

1993

Therapeutic Jurisprudence and Tort Law: A Limited Subjective Standard of Care

Daniel W. Shuman

THERAPEUTIC JURISPRUDENCE AND TORT LAW: A LIMITED SUBJECTIVE STANDARD OF CARE

*Daniel W. Shuman**

I. INTRODUCTION

THERAPEUTIC jurisprudence is a mode of legal analysis that focuses on the law's potential as a therapeutic agent.[1] Its premise is that legal rules should encourage therapeutic outcomes when it is possible to do so without offending other important normative values.[2] "Therapeutic jurisprudence simply seeks to focus attention on an often neglected ingredient in the calculus necessary for performing a sensible policy analysis of mental health law and practice — the therapeutic dimension — and to call for a systematic empirical examination of this dimension."[3] If, for example, empirical examination reveals that voluntary treatment for mental illness is more effective than involuntary treatment,[4] the law should encourage voluntary treatment and permit involuntary treatment, if at all, only after efforts

* Professor of Law, Southern Methodist University School of Law, Dallas, Texas. An earlier version of this article was presented at the Law and Mental Disability Section Program at the Association of American Law School's Annual Meeting in San Antonio, Texas, January 5, 1992. The author gratefully acknowledges a grant from the M.D. Anderson Foundation to support the preparation of this article. Laura Cushman, Grant Morris, Victoria Palacios, Michael Perlin, Robert Schopp, Ellen Solender, and David Wexler provided helpful comments on an earlier draft of this article. Fritz Harding provided invaluable research assistance in the preparation of this article.

1. DAVID B. WEXLER & BRUCE J. WINICK, ESSAYS IN THERAPEUTIC JURISPRUDENCE (1991); DAVID B. WEXLER, THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT ix (1990).

2. WEXLER & WINICK, *supra* note 1, at xi.

3. *Id.* This inquiry into the therapeutic dimension of law can be analyzed from four perspectives. First, the law may play a role in producing psychological dysfunction through discouragement of necessary treatment, encouragement of unnecessary treatment, and encouragement of sick behavior or absence of responsibility. *Id.* at 19-24. Second, legal rules may explicitly seek to promote therapeutic consequences as in the case of a right to treatment. *Id.* at 24-30. Third, legal procedures may play a therapeutic role in the parties psychological response to the legal process, as contrasted with the outcome. *Id.* at 30-33. Fourth, the roles played by attorneys and judges may have therapeutic consequences for the other actors in the legal process. *Id.* at 33-37. This proposal falls within the second perspective.

4. *See* Mary L. Durham & John Q. LaFond, *A Search for the Missing Premise of Involuntary Therapeutic Commitment: Effective Treatment of the Mentally Ill*, 40 RUTGERS L. REV. 303, 310 (1988); Leonard I. Stein & Mary Ann Test, *Alternative to Mental Hospital Treatment: I. Conceptual Model, Treatment Program, and Clinical Evaluation*, 37 ARCHIVES GEN. PSYCHIATRY 392 (1980); Bruce J. Winick, *Competency to Consent to Voluntary Hospitalization: A Therapeutic Jurisprudence Analysis of* Zinermon v. Burch, 14 INT'L J.L. & PSYCHIATRY 169 (1991), *cited in* WEXLER & WINICK, *supra* note 1, at 83.

to encourage voluntary treatment have failed.[5] In contrast, if empirical examination reveals that a physician-patient or psychotherapist-patient privilege does not result in more effective psychotherapy, then it cannot be justified on therapeutic jurisprudence grounds.[6]

The insights from therapeutic jurisprudence are particularly relevant to fault based tort law.[7] The goals of fault based tort law are compensation and deterrence.[8] Tort judgments are intended to compensate the injured and to deter potential injurers from engaging in unsafe conduct. Thus, tort law and therapeutic jurisprudence share a common agenda, the reduction of injury and the restoration of the injured. This article will explore the first item of that common agenda, deterring injury-producing conduct.

The goal of deterrence is, however, compromised by a conjunctive requirement of tort law. Only when the two goals of deterrence and compensation coincide in a case are tort sanctions available. Unreasonably unsafe conduct that does not result in injury is not subject to tort sanctions,[9] and dangerous conduct that does not result in significant injury is unlikely to resort in tort sanctions.[10]

The capacity of tort law to shape behavior, even apart from the limitation on deterrence imposed by this conjunctive requirement, is admittedly problematic. Tort law standards are imprecise and uncertain.[11] The mechanism

---

5. SAMUEL J. BRAKEL ET AL., THE MENTALLY DISABLED AND THE LAW 178 n.10 (3d ed. 1985)

6. DANIEL W. SHUMAN & MYRON F. WEINER, THE PSYCHOTHERAPIST-PATIENT PRIVILEGE: A CRITICAL EXAMINATION 6 (1987). This research concludes that for the vast majority of persons the privilege does not play a role in the decision to seek therapy or to reveal information during therapy. Just because a privilege or other rule cannot be justified on therapeutic jurisprudence grounds does not necessarily yield the conclusion that the rule is not justifiable. A psychotherapist-patient privilege that cannot be justified on the utilitarian grounds that it is necessary for effective therapy might nonetheless be supported by deontological concerns with privacy as an important societal value. For a discussion of the therapeutic potential of Shuman and Weiner's research, see Jeffrey A. Klotz, *Limiting the Psychotherapist-Patient Privilege: The Therapeutic Potential*, 27 CRIM. L. BULL. 416, 417 (1991).

7. In negligence and intentional torts, fault based liability is explicit. In strict products liability, fault is purportedly not a consideration, yet it is not absent from the relevant standards. Plaintiffs must prove that the product was defective, not merely that they were injured. In practice, the test for defective products operates much like the test for negligence. *See* James A. Henderson & Theodore Eisenberg, *The Quiet Revolution in Products Liability: An Empirical Study of Legal Change*, 37 UCLA L. REV. 479, 489 (1990). Therefore, strict liability notwithstanding, it is appropriate to characterize tort law in the United States as a fault-based liability system. Moreover, the goal of removing the requirement of proving fault in strict product liability cases is to enhance its deterrent effect.

8. David G. Owen, *Deterrence and Desert in Tort Law: A Comment*, 73 CAL. L. REV. 665, 666 (1985); Richard Pierce Jr., *Institutional Aspects of Tort Reform*, 73 CAL. L. REV. 917, 917 n.1 (1985); Daniel W. Shuman, The Psychology of Deterrence in Tort Law 4 (Mar. 20, 1992) (unpublished manuscript on file with the author).

9. See Barnes v. Bovenmyer, 122 N.W.2d 312, 317 (Iowa 1963).

10. *See, e.g.*, Report of the Harvard Medical Practice Study to the State of New York, *Patients, Doctors and Lawyers: Medical Injury, Malpractice, and Patient Compensation in New York* (1990). This study revealed that fewer than one in eight patients injured by medical negligence instituted a claim for compensation and that most of the cases in which claims were not instituted involved small damage claims. *Id.* at 12.

11. To operate as an effective deterrent, tort law should articulate a clear standard of appropriate behavior that is then communicated to decisionmakers who can understand this standard and modify their conduct to avoid the tort sanctions

through which tort law is thought to affect decisionmaking rests on assumptions that lack psychiatric or psychological validation.[12] The deterrence goal of tort law rejects a normative explanation for behavior, in which tort law plays an informative rather than a coercive role. Tort law assumes, without inquiry into the literature of psychiatry or psychology, that people are aware of the potential of tort sanctions and consequently choose safer behavior to avoid these sanctions. Notwithstanding the practical problems of whether the deterrence goal of tort law actually works, and the many calls for adoption of a no fault compensation scheme,[13] fault based tort law remains vital and its demise may be greatly exaggerated.[14] There is a powerful intuitive appeal to the claim that tort law shapes behavior. As long as fault based tort liability remains, its potential as a therapeutic agent should not be ignored.[15]

An exploration of the therapeutic potential of tort law suggests an examination of the relationship between mental or emotional problems and accidents. Do mental or emotional problems play a role in accident causation? If they do, ameliorating mental and emotional problems may reduce the number of accidents and consequential injuries. Thus, if tort law can encourage appropriate[16] utilization of mental health care, if mental health care

---

> that will otherwise occur. The corpus of tort law in any jurisdiction consists of settlements, jury verdicts, trials to the court, appellate decisions, statutes, and administrative rules. This body of law rarely articulates a clear standard of appropriate behavior within a single jurisdiction. Moreover, our federal system of government results in fifty state and a federal set of rules that are infrequently the same. Even assuming the ability to predict which set of rules will apply to a multistate transaction, the ability to predict the outcome of a case based upon what a jury will do in applying those rules in a particular case is an art not a science. Thus, tort law is often criticized as increasing rather than decreasing uncertainty about standards of appropriate behavior.

Shuman, *supra* note 8, at 7-8 (footnotes omitted).

12. "Deterrence posits a psychological relationship, so it is strange that most analyses of it have ignored decision makers' emotions, perceptions, and calculations and have instead relied on deductive logic based on the premise that people are highly rational." Robert Jervis, *Introduction: Approach and Assumptions, in* PSYCHOLOGY AND DETERRENCE 1 (Robert Jervis ed., 1985). (Jervis' observations about deterrence focus on its application to international conflict; however, this observation is equally perceptive concerning the role of deterrence in tort law.)

13. JEFFERY O'CONNELL, THE INJURY INDUSTRY AND THE REMEDY OF NO FAULT INSURANCE 94-105 (1971); Stephen B. Sugerman, *Doing Away With Tort Law*, 73 CAL. L. REV. 555, 659-64 (1985).

14. With apologies to Samuel Clemens.

15. The effort to transform fault based tort law into a no fault compensation system has been criticized, among other grounds, on the basis that any possibility of effective deterrence would be lost. Craig Brown, *Deterrence in Tort and No-Fault: The New Zealand Experience*, 73 CAL. L. REV. 976, 976-77 (1985); Thomas A. Ford, *The Fault With "No Fault"*, 61 A.B.A. J. 1071, 1072 (1975); Elisabeth M. Landes, *Insurance, Liability, and Accidents: A Theoretical and Empirical Investigation of the Effects of No-Fault Insurance*, 25 J.L. & ECON. 49, 50, 57-65 (1982).

16. Research on medical care has revealed that one out of every hundred hospitalized patients is injured as the result of negligent medical care. Report Harvard Medical Practice Study to the State of New York, *Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990). Because diagnosis and treatment have certain risks associated with it, unnecessary or inappropriate care should not be encouraged.

is effective in treating mental or emotional problems,[17] and if ameliorating mental or emotional problems can reduce the number of accidents, the accident reduction goals of tort law and therapeutic jurisprudence coalesce to support that result.

II. THE RELATIONSHIP OF ACCIDENTAL INJURY AND MENTAL OR EMOTIONAL PROBLEMS

Tort law doctrine and scholarship have largely ignored the psychology of deterrence, why people behave the way they do and how tort law shapes behavior.[18] Instead, economic analysis has dominated the examination of the impact of tort law based upon an unverified assumption that people act rationally and that the object of that rational behavior is the accumulation of wealth.[19] Thus, it is not surprising that the impact of tort law on the mentally ill has also been largely ignored.[20]

There is a developing body of legal scholarship on the impact of tort liability on those who treat the mentally ill.[21] Ironically, the therapeutic consequences of tort liability on the mentally ill has escaped direct scrutiny.[22] This approach sends an implicit message that reinforces a model of learned helplessness for mentally ill persons. It teaches that the locus of control for mentally ill persons is external rather than internal.[23] To address the problems of the clients each profession is intended to serve, the legal profession focuses on the problems of the mental health profession, without directly addressing the client/patient's interests.[24] The appropriate inquiry

17. The demand for cost-effective treatments by third party payors has generated substantial outcome research for mental health care. One type of care that has generated a massive amount of research is psychotherapy. *See, e.g.*, Nathan B. Epstein & Louis A. Vlok, *Research on the Results of Psychotherapy: A Summary of Evidence*, 138 AM. J. PSYCHIATRY 1027 (1981); Perry London & Gerald Klerman, *Evaluating Psychotherapy*, 139 AM. J. PSYCHIATRY 709 (1982). While significant methodological difficulties plague the research on this question, there seems to be general agreement from this research that psychotherapy may be effective in treating individuals suffering from nonpsychotic depression or moderate anxieties. Beyond that there is a divergence of opinion.

18. Shuman, *supra* note 8.

19. *See, e.g.*, GUIDO CALABRESI, THE COST OF ACCIDENTS 24-30 (1970); WILLIAM LANDES & RICHARD POSNER, THE ECONOMIC STRUCTURE OF TORT LAW (1987); R. H. Coase, *The Problem of Social Cost*, 3 J.L. & ECON. 1 (1960).

20. James W. Ellis, *Tort Responsibility of Mentally Disabled Persons*, 1981 AM. B. FOUND. RES. J. 1079, 1079-81 (1981).

21. *See* David B. Wexler & Robert F. Schopp, *How and When to Correct for Juror Hindsight Bias in Mental Health Malpractice Litigation: Some Preliminary Observations*, 7 BEHAV. SCI. & L. 485 (1989); David B. Wexler & Robert F. Schopp, *Shooting Yourself in the Foot with Due Care: Psychotherapists and Crystallized Standards of Tort Liability*, 17 J. PSYCHIATRY & L. 13 (1989).

22. Even in articles that do address the therapeutic consequences of tort law, the interests of the client/patient are addressed indirectly, as a function of the law's impact on the mental health professional. *See* Robert F. Schopp, *The Psychotherapist's Duty to Protect the Public: The Appropriate Standard and the Foundation in Legal Theory and Empirical Premises*, 70 NEB. L. REV. 327 (1991).

23. *See* discussion of attribution theory, *infra* notes 63-64 and accompanying text.

24. Although there are a number of articles that address the tort liability of the mentally ill, they tend to focus on whether it is consistent with fault based tort liability. *See* James Barr Ames, *Law and Morals*, 22 HARV. L. REV. 97, 99-100 (1908); Francis H. Bohlen, *Liability in*

ought to consider the therapeutic consequence of tort liability on the mentally ill. The sensible premise of therapeutic jurisprudence suggests that if mental illness plays a role in accident causation, tort liability rules should, whenever possible to do so without offending other important normative values, encourage and support voluntary, efficacious treatment.[25]

The suggestion that the accident reduction goals of tort law and therapeutic jurisprudence coalesce points to an exploration of the role of mental illness in accidents. It is often assumed, but has less often been the subject of careful investigation, that there is a linkage between mental illness and accidents, particularly automobile accidents.[26] The potential impact of this linkage is significant given the human and economic cost of accidents and the extent of mental illness in our society. The direct and indirect cost of accidents in the United States, one-fifth of which involve motor vehicles, is estimated to be 175.9 billion dollars per year.[27] Current estimates of the level of individuals in the United States who suffer from a mental disorder are at fourteen percent of the population.[28] Additionally, research suggests that certain categories of mentally ill individuals have lower rates of accidents after treatment.[29]

Notwithstanding this assumption, there is good reason to question the linkage between mental illness and accidents. The frequency with which the mentally ill cause accidents, at least as reflected in one crude indicator, appellate caselaw, does not suggest that seriously mentally ill persons account for a disproportionate number of accidents.[30] More directly, recent accident

---

Tort of Infants and Insane Persons, 23 MICH. L. REV. 9, 31-34 (1924); William B. Hornblower, *Insanity and the Law of Negligence*, 5 COLUM. L. REV. 278, 278 (1905). These articles are not concerned with the way the mentally ill might behave in light of these rules.

25. *See* Durham & LaFond, Stein & Test, and Winick, *supra* note 4.

26. Laura A. Cushman et al., *Psychiatric Disorders and Motor Vehicle Accidents*, 67 PSYCHOL. REP. 483, 484 (1990).

27. DEBORAH F. HENSLER ET AL., COMPENSATION FOR ACCIDENTAL INJURIES IN THE UNITED STATES 1 (Rand 1991).

28. Cushman, *supra* note 26, at 486-87. Some estimate that at any given time, one in four Americans suffers from depression, anxiety, or other emotional disorders. The President's Commission on Mental Health (1978). The extent of the problem is revealed in the fact that Valium and Librium are the most frequently prescribed drugs throughout the world. L.F. Rittelmeyer, *Minor Tranquilizers: Prescribing Practices of Primary Care Physicians*, 23 PSYCHOSOMATICS 223, 226 (1982).

29. Robert C. Eelkmena et al., *A Statistical Study on the Relationship Between Mental Illness and Traffic Accidents - A Pilot Study*, 60 AM. J. PUB. HEALTH 459, 460 (1970). Although individuals in the study discharged from a state hospital had a higher rate of accidents than a comparable group of individuals in the population who were not diagnosed as mentally ill, the groups labeled as psychotics and psychoneurotic had reduced rates of accidents following treatment. Those labeled as alcoholics and personality disorder sufferers did not respond as favorably. *Id.* at 461. The finding that accident rates of alcoholics and persons suffering from personality disorders were not reduced after hospitalization corresponds with Gottfredson and Hirschi's findings that criminal behavior and noncriminal behavior such as accidents can be explained as a lack of self-control caused by ineffective child rearing. MICHAEL R. GOTTFREDSON & TRAVIS HIRSCHI, A GENERAL THEORY OF CRIME 91-97 (1990).

30. William J. Curran, *Tort Liability of the Mentally Ill and Mentally Deficient*, 21 OHIO ST. L.J. 52, 64 (1960). Curran's survey of the case law as of 1960 reveals few cases in which a tort "insanity defense" was raised. Accepting the accuracy of this survey, it is far from clear whether this is a valid indicator of the frequency with which the mentally ill cause accidents.

research questions the linkage between mental illness and the rate of automobile accidents.[31] Moreover, mental illness may serve as a screening factor to exclude people from positions of risk creation. Mental illness is a ground to deny or suspend a license to practice law,[32] medicine,[33] and psychology.[34] Additionally, mental illness is a ground to deny or suspend a license to operate a motor vehicle.[35] Mental illness is a also a practical disqualifying factor in business. Acting crazy in a working environment quickly excludes one from the business world.

Therefore, the therapeutic potential of tort law is likely to be limited if focused exclusively on those who suffer from major mental illness. To achieve a broader impact, concern with the therapeutic impact of tort law should not be limited to those suffering from major mental illness, but should include the walking wounded.[36] All humans confront powerlessness and the inevitability of death, regardless of race, class or gender. Our response to the loss of a job or the death of a loved one may fade with time and

---

It may be that mentally ill people commit torts with lesser frequency than those who are not mentally ill; it may be that mentally ill people commit torts with the same frequency as those who are not mentally ill but have fewer assets or insurance and are therefore sued less often; it may be that mentally ill people commit torts with the same frequency as those who are not mentally ill but that insurance companies settle rather than litigate these cases; or, it may be that mentally ill people who are sued fail to raise their illness as a defense because courts have not been receptive to this argument. Thus, appellate case law is not necessarily a reliable indicator of the nexus between mental illness and accident causation.

31. Cushman, *supra* note 26, at 487. Cushman's study of accident victims found that the percentage with psychiatric diagnoses was lower than national estimates of the percentage of the population thought subject to these diagnoses; individuals with psychiatric diagnoses were not involved in single-car accidents (where suicide might be a likely explanation) with a greater frequency than those who did have a psychiatric diagnosis; and, individuals with psychiatric diagnoses were not cited more often for inattention or failure to yield the right of way. *Id.* at 486-87. *See also* J. Isherwood et al., *Life Event Stress, Psychosocial Factors, Suicide Attempt and Auto-Accident Proclivity*, 26 J. PSYCHOSOMATIC RES. 371 (1982) (study analyzing assocation between life event stress and suicide attempts as well as auto accidents). This research parallels the research addressing another myth about the mentally ill, that they are more dangerous than non-mentally ill persons. *See* Michael Perlin, *On "Sanism"*, 46 SMU L. REV. 373, (1992). Although that research focuses on intentional rather than negligent acts, both findings dispel myths that we should be more fearful of harm at the hands of the mentally ill. Linda A. Teplin, *The Criminality of the Mentally Ill: A Dangerous Misconception*, 142 AM. J. PSYCHIATRY 593, 595 (1985).

32. TEX. GOV'T CODE ANN. § 82.027(b)(2) (Vernon 1988).

33. TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.08(16) (Vernon Supp. 1992).

34. TEX. REV. CIV. STAT. ANN. art. 4512c, § 11(d)(3) (Vernon Supp. 1992).

35. TEX. REV. CIV. STAT. ANN. art. 6687b, § 4(5) & (7) (Vernon Supp. 1992). Although mental illness or incapacity remains a ground to deny or suspend a driver's license, procedures that do not provide the driver a timely hearing and opportunity to be heard on this issue have been found unconstitutional. Freitag v. Carter, 489 F.2d 1377, 1382 (7th Cir. 1973); Jones v. Penny, 387 F. Supp. 383, 394-95 (M.D.N.C. 1974).

Those mentally ill persons who are involuntarily hospitalized or found incompetent may be automatically denied driving privileges. BRAKEL, *supra* note 5, at 493-505. It is not at all clear, however, that the walking wounded, those with minor mental or emotional problems, report these problems to the appropriate state agencies of their own volition or that these problems are reported by their therapists.

36. Others have referred to what I understand to be the same group as the worried well. *See, e.g.*, Epstein & Vlok, *supra* note 17, at 1034; James E. Barrett et al., *The Prevalence of Psychiatric Disorders in a Primary Care Practice*, 45 ARCHIVES GEN. PSYCHIATRY 1100 (1988).

escape diagnosis as a major mental illness.[37] Nonetheless, its impact may be profound. At a minimum, it may affect our concentration and responsiveness. Inclusion of the walking wounded in a discussion of the therapeutic impact of tort law is sound both in terms of expanding the therapeutic potential of tort law and in light of the current research on stress.

Research seeking to identify the characteristics of accident-prone drivers initially focused on physical and psychological characteristics viewed as stable.[38] This research suggested a correlation between auto accidents and psychosocial variables such as aggressiveness, depression, and social maladjustment.[39] However, the inability of these variables to explain accident rates for individual drivers over time indicated the limitations of the research that suggested accident proneness was a stable characteristic of certain drivers.[40] In addition, research has dispelled the fiction that removing the mythical five percent of the drivers who cause fifty percent of the accidents would have a significant impact on the total number of automobile accidents.[41]

These findings led to research focusing on the relationship of accident rates to life events (i.e., change in marital status, change in employment status, change in financial status), the degree of adjustment such events require, and the subjective stress experienced from these changes.[42] This research

37. For example, AMERICAN PSYCHIATRIC ASSOCIATION'S DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 217 (3d ed. revised 1987) (DSM-III-R) describes the diagnostic criteria for a Major Depressive Episode to include a depressed mood or loss of interest in virtually all activities for at least two weeks. However, the diagnostic criteria excludes individuals who experience normal reactions to losing a loved one. *Id.* at 218-19. A depressed mood or loss of interest in all activities is considered a normal reaction to such an event and is not considered a mental disorder if, for example, it only lasts for a matter of months. *Id.* at 360-61.

38. *See* Fleming James, Jr. & John J. Dickinson, *Accident Proneness and Accident Law*, 63 HARV. L. REV. 769, 772-75 (1950).

39. MORRIS S. SCHULZINGER, THE ACCIDENT SYNDROME, 14-15 (1956); A.E. Suchman, *Cultural and Social Factors in Accident Occurrence and Control*, 7 J. OCCUP. MED. 487, 488 (1965); Stanford G. Wrogg, *The Role of Emotions in Industrial Accidents*, 3 ARCHIVES ENV. HEALTH 519 (1961).

40. D.H. Schuster & J.P. Guilford, *The Psychometric Prediction of Problem Drivers*, 6 HUM. FACTORS 393 (1964).

41. DEPARTMENT OF TRANSPORTATION DRIVER-BEHAVIOR AND ACCIDENT INVOLVEMENT: IMPLICATIONS FOR TORT LIABILITY 75 (1970).

42. These events are described in Thomas H. Holmes & Richard R. Rahe, *The Social Readjustment Rating Scale*, 11 J. PSYCHOSOMATIC RES. 213, 216 (1967):

Rank	Life Event	Mean Value
1	Death of spouse	100
2	Divorce	73
3	Marital separation	65
4	Jail Term	63
5	Death of close family member	63
6	Personal injury or illness	53
7	Marriage	50
8	Fired at work	47
9	Marital reconciliation	45
10	Retirement	45
11	Change in health of family member	44
12	Pregnancy	40
13	Sex difficulties	39

pointed to a significant correlation between life changes, subjective stress, and accident rates.[43] Transient situational stress, which everyone may experience at some point in their lives, is currently regarded as a significant factor in accident causation. "These studies suggest that recent life events (e.g., birth of a child, divorce, death of a friend or relative, change of job, financial change) that bring about a significant change in an individual's ongoing life pattern may cause psychological turmoil that can exacerbate the risk of accident or illness."[44] From the perspective of therapeutic jurisprudence and the accident reduction goal of tort law, the correlation between stress and accidents points away from an exclusive focus on those who suffer from a major mental illness, such as schizophrenia, and toward inclusion of the walking wounded - individuals whose life changes and subjective response to

14	Gain of new family member	39
15	Business readjustment	39
16	Change in financial state	38
17	Death of close friend	37
18	Change to different line of work	36
19	Change in number of arguments with spouse	35
20	Mortgage over $10,000	31
21	Foreclosure of mortgage or loan	30
22	Change in responsibilities at work	29
23	Son or daughter leaving home	29
24	Trouble with in-laws	29
25	Outstanding personal achievement	28
26	Wife begin or stop work	26
27	Begin or end school	26
28	Change in living conditions	25
29	Revision of personal habits	24
30	Trouble with boss	23
31	Change in work hours or conditions	20
32	Change in residence	20
33	Change in schools	20
34	Change in recreation	19
35	Change in church activities	19
36	Change in social activities	18
37	Mortgage or loan less than $10,000	17
38	Change in sleeping habits	16
39	Change in number of family get-togethers	15
40	Change in eating habits	15
41	Vacation	13
42	Christmas	12
43	Minor violations of the law	11

43. L. McMurray, *Emotional Stress and Driving Performance: The Effect of Divorce*, 1 BEHAV. RES. IN HIGHWAY SAFETY 100 (1970) (accident rates for individuals in divorce proceedings were doubled in the six months preceding and following the date of the divorce); Melvin L. Selzer et al., *Fatal Accidents: The Role of Psychopathology, Social Stress, and Acute Disturbance*, 124 AM. J. PSYCHIATRY 1028, 1029 (1968) (fifty-two percent of drivers found at fault in fatal automobile accidents had previously experienced interpersonal, employment, or financial stresses as contrasted with eighteen percent of the control group); Melvin L. Selzer & Amiram Vinokur, *Life Events, Subjective Stress, and Traffic Accidents*, 131 AM. J. PSYCHIATRY 903, 904-05 (1974) (demographic and personality variables were not statistically significantly correlated with accident causation as contrasted with life changes and subjective stress, i.e., serious disturbance with spouse of parents, serious pressure on the job or at school, serious financial disturbance).

44. James C. Helmkamp & Craig M. Bone, *The Effect of Time in a New Job on Hospitalization Rates for Accidents and Injuries in the U.S. Navy, 1977 through 1983*, 29 J. OCCUPATIONAL MED. 653, 658 (1987).

stress significantly reduce their concentration or responsiveness.[45]

The magnitude of this problem is illustrated by recent research on stress and professions. A level of emotional discomfort seems to be a consequence of professional career choices. In research conducted in the 1980s during the boom market for attorneys, Benjamin, Kaszniak, Sales, and Shanfield found in an Arizona study that prospective law students' levels of depression were comparable to that found in the general population of three to nine percent.[46] By late spring of the first year of law school thirty-two percent of the law students reported that they were depressed, and by the third year forty percent of the students reported that they were depressed.[47] Two years following graduation from law school, seventeen percent reported that they were depressed. A subsequent study of practicing attorneys in the state of Washington by Benjamin, Darling, and Sales found that nineteen percent of the lawyers reported depression.[48] Although major mental illness may exclude people from practicing law, medicine, or psychology, participating in these activities may create a level of stress that is positively correlated with the risk of injury.[49]

III. A LIMITED SUBJECTIVE STANDARD OF CARE

How does tort law respond to this understanding of accident causation? Does tort law ask only that we do the best we can? Is mental illness or transient situational stress factored into the evaluation of a defendant's tort liability? Contract law recognizes mental illness as an exculpatory condition under the label of contractual capacity.[50] Criminal law recognizes mental illness as an exculpatory condition under an insanity defense, negation of intent, or diminished capacity.[51] In contrast, tort law does not recognize mental illness as an exculpatory condition. With a single exception, American jurisdictions refuse to take the defendant's mental illness or other emotional problems into account in formulating the relevant standard of care in tort cases.[52] Holmes' classic exposition of this position is often cited as the justification for the objective standard of care in American tort law.

---

45. *See, e.g.*, David DuBois et al., *Accident Reduction Through Stress Management*, 1 J. BUS. & PSYCHOL. 5 (1986).

46. G. Andrew H. Benjamin et al., *The Role of Legal Education in Producing Psychological Distress Among Law Students*, AM. B. FOUND. RES. J. 225, 225 (1986). *See also* Lennart Levi, *Occupational Stress: Spice of Life or Kiss of Death?*, 45 AM. PSYCHOL. 1142, 1142 (1990).

47. Benjamin, *supra* note 46, at 236.

48. G. Andrew H. Benjamin et al., *The Prevalence of Depression, Alcohol, and Cocaine Abuse Among United States Lawyers*, 13 INT'L. J. L. AND PSYCHIATRY 233, 240 (1990).

49. The effects of professional stress are certainly not limited to the practice of law. One state wide study of admission records of community mental health centers found a disproportion percentage of hospital and health care workers experiencing mental health problems. Michael J. Colligan et al., *Occupational Incidence Rates of Mental Health Disorders*, 3 J. HUM. STRESS 34, 36 (1977).

50. DANIEL W. SHUMAN, PSYCHIATRIC AND PSYCHOLOGICAL EVIDENCE 361 (1986).

51. *Id.* at 273-78.

52. Hudnall v. Sellner, 800 F.2d 377, 384 (4th Cir. 1986), *cert. denied*, 479 U.S. 1069 (1987); RESTATEMENT (SECOND) OF TORTS, § 283(B) (1965). "Unless the actor is a child, his insanity or other mental deficiency does not relieve the actor from liability for conduct which does not conform to the standard of a reasonable man under like circumstances." *Id.*

> The standards of the law are standards of general application. The law takes no account of the infinite varieties of temperament, intellect, and education which make the internal character of a given act so different in different men. It does not attempt to see men as God sees them, for more than one sufficient reason. In the first place, the impossibility of nicely measuring a man's powers and limitations is far clearer than that of ascertaining his knowledge of law, which has been thought to account for what is called the presumption that every man knows the law. But a more satisfactory explanation is, that, when men live in society, a certain average of conduct, a sacrifice of individual peculiarities going beyond a certain point, is necessary to the general welfare. If, for instance, a man is born hasty and awkward, is always having accidents and hurting himself and his neighbors, no doubt his congenital defects will be allowed for in the courts of Heaven, but his slips are no less troublesome to his neighbors than if they sprang from guilty neglect. His neighbors accordingly require him, at his proper peril, to come up to their standard, and the courts which they establish decline to take his personal equation into account.[53]

Holmes justified the objective standard on the grounds of problems of measuring individual capacities and the right to expect a minimal level of care from one's neighbors. Others have noted as reasons advanced in favor of the rule that as between the plaintiff and defendant, the party who caused the loss should be required to compensate for the resulting harm; feared logistical problems of administering a civil insanity defense; encouraging greater care by guardians of the mentally ill; and, the risk of eroding the objective standard of care.[54]

Although tort law takes the physical illness of defendants into account by judging the conduct of physically disabled defendants against other similarly disabled persons, the conduct of mentally ill defendants is judged against those who do not suffer from a similar disability.[55] Interestingly, many of the arguments against a subjective standard of care apply with equal force in the case of physically ill defendants. Specifically, the argument that as between the plaintiff and defendant, the party who caused the loss should be required to compensate for the resulting harm, does not suggest a distinction in the standard of care for physically and mentally incapacitated defendants.[56] Thus, the argument that it is necessary to maintain the dichotomy between a subjective standard for the physically incapacitated and an objective standard for the mentally incapacitated to serve the goal of compensating innocent plaintiffs is unconvincing.

The objective standard of care has been consistently criticized in the aca-

---

53. O.W. HOLMES JR., THE COMMON LAW 86-87 (1963).

54. James B. Ellis, *Tort Responsibility of Mentally Disabled Persons*, 1981 AM. B. FOUND. RES. J. 1079, 1083-84 (1981). *See also* William J. Curran, *Tort Liability of the Mentally Ill and Deficient*, 21 OHIO ST. L.J. 52, 54 (1960).

55. Warren A. Seavey, *Negligence: Subjective or Objective?*, 41 HARV. L. REV. 1, 13-14 (1927).

56. Ultimately the roots of the distinction may be found in society's unfounded myths about the mentally ill. *See* Perlin, *supra* note 31.

demic literature as conceptually unsound in a fault based liability system.[57] Prior to the 19th century, when strict liability dominated tort law and the morally laden concept of fault was largely irrelevant to the determination of liability, it may have been logical to measure the behavior of the mentally ill and non-mentally ill by a single standard. However, in the fault-based system of liability that evolved in the 19th century, the single standard raises a troubling moral quandary.

Recognizing this moral quandary, I nonetheless accept the objective standard of care, with the limitations noted later, although I do not accept the reasons traditionally given for the objective standard.[58] The objective standard of care is a therapeutic agent. It encourages a therapeutic result by stating to the mentally ill and walking wounded that they cannot rely on their mental or emotional problems to avoid responsibility for their behavior or failure to initiate treatment.[59] A response from one psychotherapist, questioned about data involving mental illness and accidents, explained in vivid terms the therapeutic potential of the objective standard of care: "I hate it when you legal people interfere with the only proven motivator for the mentally ill to seek treatment because they realize that they are people responsible for their actions like everyone else."[60] If the mentally ill and walking wounded behave, as the deterrence theorists of tort law posit, like the normal population behave and rely on the threat of tort sanctions to shape their actions,[61] then the objective standard of care encourages them to

57. *See* Ellis, *supra* note 54; Curran, *supra* note 54.

58. The argument that a subjective judgment measuring individual capacity is unworkable is a smoke screen. Tort law regularly makes subjective judgments about individual capacity in other contexts. For example, tort law makes subjective judgments about the degree of impairment a plaintiff has suffered and the pain and suffering the plaintiff experienced. The argument that the party who was injured through no fault of his or her own should be compensated is more troubling. One response, which I do not find particularly satisfying, is that there are always tradeoffs in achieving any beneficial result in the law. A more satisfying response to this concern points in the direction of the wisdom implicit in comparative fault that accidents are rarely caused exclusively by one party. Thus, the example of the plaintiff injured without his or her own fault is a chimera. *See also* George J. Alexander & Thomas S. Szasz, *Mental Illness as an Excuse for Civil Wrongs*, 43 NOTRE DAME L. REV. 24, 33 (1967) (arguing in favor of holding the mentally ill liable for their torts on libertarian grounds).

59. Stephen J. Morse, *Crazy Behavior, Moral, and Mental Health Law*, 51 S. CAL. L. REV. 527 (1978); John T. Monahan, *Abolish the Insanity Defense?—Not Yet*, 26 RUTGERS L. REV. 719 (1973). *See also* David B. Wexler, *Inducing Therapeutic Compliance Through the Criminal Law*, 14 L. & PSYCHOL. REV. 43 (1990) (the author relies on research that has found that recidivists with known, treatable low serotonin levels are correlated with higher rates of recidivism, to argue that defendants should be subject to enhanced punishment for failure to avail themselves of treatment).

60. Telephone Interview with anonymous psychotherapist (Oct. 1991). This response may be explained in alternate ways. It may be that the psychotherapist is simply describing a clinical observation that mentally ill people who have sought treatment with this therapist have mentioned that concern with legal responsibility for their actions is a reason for seeking therapy. Alternatively, it may be that the psychotherapist is expressing a personal concern with malpractice liability that translates as, "do not exculpate the mentally ill; rather, hold them, not their therapists, solely responsible for their conduct and not as the court did in *Tarasoff*." *See* Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334 (Cal. 1976).

61. Shuman, *supra* note 8. Beyond the problems that all individuals have in learning about and using tort law in their decisions, the potential impact of mental illness on cognitive and volitional capacity presents a more serious challenge to the deterrent goal of tort law.

behave responsibly and seek treatment.

Research from numerous psychological perspectives supports the conclusion that a person's perception of free choice and responsibility for behavior has a significant impact upon that behavior.[62] One explanation comes from attribution theory which explains that people behave according to their perception and understanding of events. "[A]ttributions affect our feelings about past events and our expectations about future ones, our attitudes toward other persons and our reactions to their behavior, and our conceptions of ourselves and our efforts to improve our fortunes."[63] For example, a student who attributes her failure on an exam to low ability, over which she has no control, is less likely to put substantial effort into the class than a student who attributes her failure to lack of effort, over which she has control.[64] The impact of attribution theory is not limited to normal people. In particular, attribution theory's focus on "learned helpless," attributing success or failure to forces outside of ourselves, has relevance to behavior across diagnostic categories. The import of attribution theory and numerous other psychological perspectives is that not excusing people from tort liability for their mental or emotional problems encourages them to take greater responsibility for their actions. This is revisionist therapeutic jurisprudence at its best. So far, so good.

But what of the mentally ill and walking wounded who respond to this therapeutic incentive and seek treatment which has not yet achieved its desired result? How are those who are still in treatment — the uncured — regarded by tort law? Tort law is, at best, indifferent to a defendant's efforts to receive mental health care. Seeking help does not reduce tort law's expectations of the defendant.[65] The mentally ill and walking wounded who are aware of their mental health problems and pursue treatment are held to the same standard as those who are aware of their mental health problems and refuse to pursue treatment. A defendant who has instituted a course of treatment for mental or emotional problems, has complied fully with the prescribed treatment regime, and has become preoccupied with problems raised during psychotherapy resulting in reduced concentration or responsiveness while driving which, in turn, causes an accident, is judged according to the objective standard without regard to the treatment efforts. Tort defendants receive no extra credit for extra effort in seeking treatment.

---

62. Monahan, *supra* note 59, at 721. Monahan discusses research from the locus of control, cognitive dissonance, attribution, achievement motivation, personal causation, reactance, and perceived control theories that support this conclusion. *Id.* at 721-22.

63. H.H. Kelley & J.L. Michela, *Attribution Theory and Research*, 31 ANN. REV. PSYCHOL. 457, 489 (1980).

64. Sandra Graham, *Communicating Low Ability in the Classroom: Bad Things Good Teachers Sometimes Do*, *in* ATTRIBUTION THEORY: APPLICATIONS TO ACHIEVEMENT, MENTAL HEALTH, AND INTERPERSONAL CONFLICT 17 (Sandra Graham & Valerie S. Folkes eds., 1990).

65. Seeking help may actually increase tort law's expectations for the defendant. As discussed *infra* notes 79-80 and accompanying text, knowledge gained through diagnosis or treatment of a mental health problem may increase the defendant's awareness of the risks posed by the illness and require the defendant to act with reference to that increased knowledge.

There are two responses to this criticism. Each response points to therapeutic benefits of the objective standard's indifference to treatment efforts. The first approach is tough love for tortfeasers. "Get better, no excuses accepted," may be a more powerful, albeit less nurturing motivator, than one which leaves the door open to excuses. Tort law takes a "no excuses accepted" approach in strict products liability.[66] The deterrent rationale for strict products liability rejects a good faith defense on the ground that it encourages the highest possible level of care.[67] By analogy, because best efforts at treatment do not count in tort law, people may be encouraged to seek out the most effective mental health treatment and comply fully with prescribed treatment regimes. Only successful outcomes are rewarded, not best efforts.

Another response to this criticism of no extra credit for seeking treatment is that tort law's indifference to treatment efforts may have therapeutic benefits by failing to reinforce learned helpless. Labeling those who seek treatment as less responsible for their tortious behavior could teach these individuals to behave less responsibly. Both the no excuses accepted and the avoidance of learned helplessness approach are, superficially, plausible revisionist rationales for tort law's indifference to treatment efforts. The problem with these rationales only becomes apparent when mental health treatment is examined more closely.

The failure to factor treatment efforts into the standard of care can be justified on therapeutic jurisprudence grounds only if the patient's good faith participation in treatment is the *sine qua non* of efficacious treatment. Patient cooperation in treatment is extremely important, but the failure to factor treatment efforts into the standard of care can be justified only if patient cooperation is not merely a necessary but also a sufficient condition of efficacious treatment. That approach encapsulates the magic pill approach to health care. Health care professionals have a safe, quick, and effective treatment for mental health problems. All a patient need do to be effectively treated is to follow the doctor's orders.

Application of the magic pill construct to the treatment of mental or emotional problems may be based, in part, upon a flawed analogy to the treatment of physical illness. There may be a tendency to think of treatment for mental or emotional problems based on a model of a common available treatment for physical illness that is quick and effective when the patient follows the doctor's orders. To the extent that a magical medical pill for physical illness exists, it is the use of antibiotics to treat acute bacterial infections.[68] The magical medical pill exists; the patient need only take it as pre-

66. "The rule is one of strict liability, making the seller subject to liability to the user or consumer even though he has exercised all possible care in the preparation and sale of the product." RESTATEMENT (SECOND) OF TORTS § 402A cmt. a. (1965).

67. *See* Escola v. Coca Cola Bottling Co., 150 P.2d 436, 440 (1944) (Traynor, J., concurring).

68. The chemicals used to treat specific microorganisms in infectious diseases are often referred to as antibiotics, antimicrobic, and chemotherapeutic agents. Lowell S. Young, *Antimicrobial Therapy, in* TEXTBOOK OF MEDICINE 1596 (James B. Wyngaarden et al. eds., 19th

scribed to be effectively treated. The application of this construct to the treatment of mental or emotional problems, however, is flawed for two reasons.

First, the treatment model based on physical illness is itself flawed in that it incorrectly assumes that certain common, available treatments of physical disorders are representative of the universe of treatment for physical disorders. This error corresponds to cognitive psychology's availability heuristic.[69] Although the responsiveness of some treatments for physical illnesses that we call to mind is direct and immediate when the patient follows the doctor's orders, that model is not descriptive of the universe of treatments for physical illness. The use of chemotherapy to treat certain cancers may extend over a significant time period and its long term efficacy is often unclear.[70] The efficacy of organ transplantation may be unclear for an extended period of time.[71] Uncertainty abounds in the treatment of physical illness. HIV is a sobering reminder of the limits of medicine's ability to treat physical illness and of our expectation that medicine should and will develop a magic pill to protect us from the effects of catastrophic illness. Thus, it is inaccurate to characterize the treatment model, even for physical illness, as direct and immediate with its efficacy turning exclusively on patient compliance.

Second, there is a tendency to assume that mental illness does or should respond to treatment in similar fashion to the flawed model of treatment for physical illness. As in the case of physical illness, the benefits of treatment for mental illness are not often direct or immediate and do not turn exclusively on patient cooperation.[72] Psychotherapy is commonly used to treat mental illness or disorder. Beyond the consensus that psychotherapy is effective for the treatment of nonpsychotic depression or moderate anxieties, however, there is not a consensus about its efficacy.[73]

Even when psychotherapy is an effective treatment, the benefits of therapy are not necessarily linear.[74] Psychotherapy typically entails exploration of

---

ed. 1991). The greatest success in the use of these agents has occurred in the treatment of acute bacterial infections. *Id.*

69. Amos Tversky & Daniel Kahneman, *Availability: A Heuristic for Judging Frequency and Probability, in* JUDGMENT UNDER UNCERTAINTY: HEURISTICS AND BIASES (Daniel Kahneman et al. eds., 1982).

70. I CANCER: PRINCIPLES AND PRACTICE OF ONCOLOGY 278 (Vincent T. DeVita, Jr. et al. eds., 3d ed. 1989).

71. II THE KIDNEY 2344 (Barry M. Brenner & Floyd C. Rector, Jr. eds., 4th ed. 1991).

72. The argument that treatment of mental illness is or should be immediate may superficially be fueled by Single Session Therapy (SST). *See* MOSHE TALMON, SINGLE-SESSION THERAPY: MAXIMIZING THE EFFECT OF THE FIRST (AND OFTEN ONLY) THERAPEUTIC ENCOUNTER 1-3 (1990). SST is a new approach to psychotherapy that posits that a single session may be as beneficial as multiple sessions for most patients. Apart from the question of long term outcome research for SST, its underlying premise is not that treatment is immediately effective, but rather that given the limited capacity of lengthy therapy to address many psychological problems, one session is no worse that one hundred sessions and patients will often not return for more than the initial session.

73. *See* Epstein & Veok, *supra* note 17; London & Klerman, *supra* note 17.

74. A psychoanalytic explanation for this phenomenon focuses on resistance. The work of analysis in uncovering repressed pathology is threatening to the patient and is expected to

painful issues that the patient has repressed. The amount of pain associated with these issues is likely to be positively correlated with the importance of addressing these issues in therapy. Exploration of these repressed issues may result in the patient feeling worse before feeling better. Short term bad feelings induced or exacerbated by psychotherapy are likely to affect concentration or responsiveness. Thus, psychotherapy that is effective in the long term may nonetheless increase the risk of accidental injury in the short term.

Another common treatment for mental illness or disorder is the use of psychopharmacological agents, psychoactive drugs. Treatment of mental illness or disorder with psychopharmacological agents, the treatment of choice for schizophrenic and affective disorders,[75] for example, presents a host of problems that may increase the risk of accidental injuries.[76] Not all individuals treated with psychopharmacological agents for these illnesses respond to these medications. For example, approximately twenty-five percent of schizophrenic patients have significant symptoms on traditional neuroleptic medications.[77] Even for those individuals who do respond to these medications, psychopharmacological treatment often requires an adjustment of medication over time.[78] Individuals respond differently to medication. The recommended dose may be too small and fail to ameliorate the symptoms of the illness, or too large and cause unintended decrease in cognitive function. If tort law is to encourage a therapeutic outcome it must acknowledge and accommodate these consequences of treatment.

The failure to factor treatment efforts into the standard of care cannot be justified on therapeutic jurisprudence grounds. Patients good faith participation in treatment is a necessary but not a sufficient condition of efficacious treatment. Mental health professionals do not have safe, quick, and effective treatments for all mental health problems. Good faith on the part of the patient will not invariably lead to a beneficial therapeutic outcome and, even when it ultimately does, it may result in a short term increase in the risk of accidental injury. If tort law is to be realistic in its support of patient efforts to receive efficacious treatment it must factor into the legal response a recognition that notwithstanding the patient's complete cooperation, treatment will not invariably make things better and may make things worse.

Those who respond to the objective standard's therapeutic incentive and receive a thorough psychiatric or psychological diagnosis fare even worse

---

cause the patient to invoke a host of defenses to resist therapeutic progress. Working through the resistance is at the core of the analytic process. Robert L. Stewart, *Psychoanalysis and Psychoanalytic Psychotherapy*, *in* II COMPREHENSIVE TEXTBOOK OF PSYCHIATRY/IV 1343 (Harold I. Kaplan & Benjamin J. Sadock eds., 4th ed. 1985).

75. Schizophrenic disorders are typically treated with antipsychotic medications, which do not cure the disorder, but suppress the symptoms. W. REID, TREATMENT OF THE DSM-III PSYCHIATRIC DISORDERS 13 (1983). Affective disorders are typically treated with tricyclic or tetracyclic antidepressants. *Id.* at 129-35.

76. Gerry Oster et al., *Benzodiazepine Tranquilizers and the Risk of Accidental Injury*, 80 AM. J. PUB. HEALTH 1467, 1467 (1990).

77. J.M. Davis & Regina Casper, *Antipsychotic Drugs: Clinical Pharmacology and Therapeutic Use*, 14 DRUGS 260 (1977).

78. Philip May, *Prediction of Schizophrenic Patients' Response to Pharmacotherapy*, *in* PSYCHOPHARMACOLOGY: A GENERATION OF PROGRESS (Morris A. Lipton et al. eds., 1977).

under tort law than those who ignore the symptoms of their illness. Tort law imposes a greater burden on those who discover specific knowledge of risks.[79] Increased knowledge of risks triggers a correlatively greater burden to guard against those risks. Thus, an individual who discovers that he suffers from an illness that poses risks to others owes an obligation to guard against those risks that would not exist if the illness had not been discovered. An example from the realm of physical illnesses is illustrative. An individual who is aware that he is HIV positive may be liable in tort for failing to disclose this information to a sexual partner who becomes infected, where an individual who has no reason to believe that he is HIV positive and transmits the disease to a sexual partner would not be.[80] Similarly, an individual who has received a diagnosis of manic-depression is put on notice of the risks of the cyclical nature of this illness. Thus, as contrasted with an undiagnosed manic-depressive, the person who has received the diagnosis owes a duty to guard against the risk of accidental injury to others posed by this illness.

If tort law operates as an incentive for behavior, the objective standard of care's indifference to treatment and harsh response to diagnosis seems unlikely to encourage the diagnosis or treatment of mental or emotional problems for either the seriously mentally ill or the walking wounded. A more precise accommodation of the interests implicated by the tort system requires a distinction in approach for those who sought treatment prior to the injury producing conduct at issue and those who did not. The objective standard encourages the mentally ill and walking wounded to behave responsibly and seek treatment. It should remain as an incentive for those who did not seek treatment prior to the injury-producing conduct at issue. However, for those who have behaved responsibly and sought treatment prior to the injury-producing conduct, the objective standard ignores or frustrates their efforts.

In the case of a defendant who initiated a regime of treatment for a mental or emotional problem *before* the injury-producing conduct at issue, the objective standard of care should be modified in favor of a limited subjective standard of care that evaluates the defendant's conduct in light of the treatment received. If the defendant instituted treatment prior to the injury producing conduct and complied fully with the treatment regime, the defendant should not singularly bear the risk that the treatment has not to date been efficacious. This result seems particularly appropriate in light of the emergence of comparative negligence.[81]

---

79. "The standard of the reasonable man requires only a minimum of attention, perception, memory, knowledge, intelligence, and judgment in order to recognize the existence of the risk. If the actor has in fact more than the minimum of these qualities, he is required to exercise these superior qualities that he has in a reasonable manner under the circumstances. The standard becomes, in other words, that of a reasonable man with such superior qualities." RESTATEMENT (SECOND) OF TORTS § 289, cmt m.

80. Richard C. Schoenstein, Note, *Standards of Conduct, Multiple Defendants and Full Recovery in Tort Liability for the Transmission of Human Immunodeficiency Virus*, 18 HOFSTRA L. REV. 37, 42 (1989).

81. Ellis, *supra* note 54, at 1097. An implicit assumption that underlies comparative negligence is that accidents are seldom caused exclusively by one party. Typically, it is a combina-

This distinction draws implicit support from the case law. An exception recognized in some jurisdictions to the rule that mental illness is not factored into the standard of care for tort defendants is that sudden and unexpected mental illness that affects the capacity of the defendant to conform to the standards of a reasonable person excuses the defendant from being held to the objective standard of care.[82] Without regard to the psychological reality this rule assumes about the occurrence of sudden and unexpected episodes of mental illness, the rationale for this exception is germane to the modification of the standard of care proposed. When the defendant has no notice of the mental illness, there is nothing that the defendant can do to reduce the risk posed by the mental illness. When the defendant has notice of the mental illness, the defendant can act to reduce the risk. Notice of the illness, therefore, requires action to reduce that risk.[83] This action may involve a constellation of responses including avoiding certain behaviors (i.e. driving an automobile) and securing treatment for the mental illness. If obtaining treatment is a reasonable response to notice of the mental illness, then obtaining treatment should be factored into the measurement of the reasonableness of the defendant's conduct.

This distinction also draws implicit support from the use of evidence of mental disability in another context. Evidence of the defendant's mental disability offered in mitigation of the death penalty must be considered by the

---

tion of activities that result in injury-producing behavior. Thus, it is inappropriate to visit responsibility for the injury exclusively on one party. In the sense in which comparative negligence is typically used, fault or negligence is apportioned among the parties whose conduct proximately caused the injury. I use the concept here more broadly when I speak about the patient not singularly bearing the risk that the treatment has not yet been efficacious. I am not suggesting that a third party - the therapist or psychiatric researchers — has proximately contributed to the plaintiff's injury in the way that term is used as a legal term of art. Rather, I am suggesting that the patient who has pursued treatment in good faith which has not yet been effective shares the responsibility, although not necessarily the blame, for that result with the therapist who may not have chosen the best therapy and/or the researchers who may have not discovered a more efficacious therapy. This line of reasoning raises a troubling problem for the limited subjective standard of care. Should individuals for whom no effective treatment is currently known, i.e., personality disorders, benefit from its application?

82. Breunig v. American Family Ins. Co., 173 N.W.2d 619 (Wis. 1970).

> We think the statement that insanity is no defense is too broad when it is applied to a negligence case where the driver is suddenly overcome without forewarning by a mental disability or disorder which incapacitates him from conforming his conduct to the standards of a reasonable man under like circumstances.

Id. at 624. *See also* Kuhn v. Zabotsky, 224 N.E.2d 137, 141 (1967) (denying insanity defense to a civil cause of action).

83. There is, of course, an illogic built into the exception. It assumes that mental illness has no debilitating affect on the capacity of the defendant to seek treatment. The proliferation of a second generation of "in need of treatment" standards for civil commitment address mentally ill individuals who are in need of treatment and who are incapacitated and unable to recognize that need as a result of their illness. TEX. HEALTH & SAFETY CODE ANN. § 574.034 (Vernon 1992); WASH. REV. CODE ANN. § 71.05.020(1) (Wash. Supp. 1989). These statutes assume the existence of a population of mentally ill individuals who are by reason of their illness incapable of ascertaining their need for treatment. Cliff P. Stromberg & Alan A. Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 HARV. J. ON LEGIS. 275, 301-02 (1983).

sentencing authority.[84] Evidence of the defendant's mental disability is more likely to be effective in mitigation of the death penalty when the defendant received mental health care before committing the crime.[85] This is arguably because prior mental health care offers baseline evidence of the defendant's mental illness outside the context of the instant proceeding. Alternatively, it may reflect a common sense construct used by jurors in administration of the insanity defense.[86] Those who sought help before their current legal troubles may be considered less morally blameworthy than those who did not seek help and caused harm. The use of a subjective standard of care for those who sought help before the tortious conduct at issue is supported by a similar common sense construct.

Mentally ill and walking wounded defendants who instituted treatment prior to their injury-producing conduct should be judged on a limited subjective standard of care that takes their efforts at treatment into account and encourages them to use their knowledge of their illness to the greatest effect. Since the proposed rule is designed to encourage treatment to reduce the risk of accidental injury, the first conjunctive element of the test is that the defendant must have instituted treatment in good faith prior to the injury-producing conduct. If the defendant did not initiate treatment prior to the injury-producing conduct, the defendant would not be judged on the modified standard of care but, instead, on the traditional objective standard of care[87]—no therapeutic efforts, no special therapeutic jurisprudence standard. The date the patient initiated treatment is readily verifiable since records of patient care are required by professional regulation[88] and each patient's treatment results in a paper trail of checks, receipts, and insurance claim forms.

If the defendant initiated treatment but missed therapy sessions or failed to take prescribed medication[89] or otherwise failed to comply fully with the treatment regime, then the defendant should not be judged on the limited subjective standard of care. Although not necessarily sufficient in and of itself, patient cooperation is a necessary condition of efficacious treatment. The limited subjective standard of care is intended to support compliance

84. Penry v. Lynaugh, 492 U.S. 302, 327-28 (1989); Lockett v. United States, 438 U.S. 586, 605-08 (1978).

85. Lawrence White, *The Mental Illness Defense in the Capital Penalty Hearing*, 5 BEHAV. SCI. & L. 411, 417 (1987).

86. *See* Norman J. Finkel, *Maligning and Misconstruing Juror's Insanity Verdicts: A Rebuttal*, 1 FORENSIC REP. 97, 107 (1988).

87. Even in the case of a defendant who sought treatment by making a timely appointment but was involved in an accident before treatment could begin, I would favor encouraging treatment by application of the modified standard. This situation does admittedly present other problems, such as lack of a baseline from which to gauge the defendant's conduct.

88. *See, e.g.*, Tex. State Board of Examiners of Psychologists, 22 TEX. ADMIN. CODE § 465.22 (1987) (Record Maintenance) (requirement that psychologists maintain accurate, current, and pertinent records of psychological services).

89. Stuyvesant Assoc. v. Doe, 534 A.2d 448, 450 (N.J. Super. Ct. App. Div. 1987) (defendant-tenant, diagnosed as a schizophrenic, who failed to appear for regular injection of prolixine decanate without providing an explanation, became delusional, damaged rental dwelling, was subject to eviction and liable for property damage).

with prescribed treatment. Only therapeutic good faith justifies application of the modified standard of care.

An illustrative case is *Johnson v. Lambotte*.[90] The defendant, Johnson, was an involuntarily committed patient who had received electro-convulsive treatment and thorazine for her "chronic schizophrenic state of paranoid type." Johnson left the hospital unnoticed by the hospital staff, found a car with the motor running, and drove it into Lambotte's car. Lambotte sued for the resulting damages. The court did not consider Johnson's mental illness relevant under the traditional objective standard of care. Nor should mental illness trigger the limited subjective standard of care, both because she did not initiate treatment voluntarily[91] and because she abandoned treatment prematurely. Since no therapeutic good faith was shown, no special therapeutic jurisprudence standard should be applied.

A more troubling problem is the individual who seeks treatment that is unavailable due to the location or cost. Mental health care for the poor has been largely unavailable.[92] The incidence of increasing unemployment, lack of adequate insurance, and managed care contributes to significant financial limits on access to mental health care. There are cogent social policy reasons for using the same modified standard of care for the person making a good faith effort to obtain treatment that is financially unavailable and for the person who has begun the process of treatment. This extension of the limited subjective standard of care is, however, problematic. It will be more difficult to document efforts to secure treatment and to judge each person's ability to afford mental care.

Another difficult question is how to decide which treatments should trigger the limited standard of care. A broad array of treatments and mental health professionals exist. Tort law should not be indifferent to the defendant's choice of treatment. Only those treatments that have been proven effective through rigorous scientific studies should trigger the limited standard of care. The unknowns may dominate mental health care. A treatment currently labeled as fringe may one day justify recognition as a safe and effective treatment of choice for certain mental disorders. Yet, if the therapeutic goal of a limited standard of care is efficacious treatment, only resort to treatments that have been shown to be effective in well-designed studies should be supported by the limited subjective standard of care. Unproven treatments are pursued at the risk of forgoing the beneficial application of the limited standard of care. There is a developing literature on outcome research in

90. 363 P.2d 165 (Colo. 1961).

91. The distinction between voluntary and involuntary mental health care is admittedly illusory. Janet A. Gilboy and John R. Schmidt, *Voluntary Hospitalization of the Mentally Ill*, 66 NW. U. L. REV. 429, 430 (1971). Some voluntary patients seek care only in response to threats of job loss, divorce, or involuntary hospitalization. Some involuntary patients receive care on an involuntary basis because of concerns regarding their capacity to consent to voluntary care or fears that they will seek premature release.

92. BARBARA LERNER, THERAPY IN THE GHETTO: POLITICAL IMPOTENCE AND PERSONAL DISINTEGRATION 5 (1970); S. Garfield, *Research in Client Variable in Psychotherapy, in* HANDBOOK OF PSYCHOTHERAPY AND BEHAVIOR CHANGE 213 (S. Garfield & Allen Bergin eds., 1986).

health care precipitated by cost conscious third party payers — insurance companies and governmental entities.[93] The same concerns with efficacious outcomes are germane to therapeutic jurisprudence and provide a body of research from which consumers of health care and tort law may draw.

If the judge or jury finds that the first element of the test (institution of efficacious treatment prior to the injury producing conduct) has been satisfied, it should then proceed to the second prong of the test and consider the impact of the defendant's mental or emotional problems and treatment on the defendant's conduct. The second prong of the test asks the fact finder to decide whether the defendant performed as well as society is entitled to expect such a person to behave, considering their mental or emotional problem and the treatment obtained. Tort law considers whether a blind defendant behaved as well as society should expect a blind person to behave under the circumstances.[94] Similarly, tort law should consider whether a defendant with a mental or emotional problem behaved as well as society should expect a person to behave given the mental or emotional problems and treatment obtained. If the defendant has performed as well as society should reasonably expect given the defendant's mental and emotional problems and the treatment received, then the defendant has met the modified standard of care.

The limited subjective standard of care should not be misconstrued as a grant of immunity to the mentally ill and walking wounded. Its application will not invariably result in a lowered expectation for the defendant's behavior. Consider the case of a person who has completed a course of therapy for stress management.[95] The goal of stress management is to teach individuals to manage their physiological and psychological reactions to stressful situations. One year later, the person experiences significant stress but does not use the stress management techniques learned. As a consequence, the person fails to concentrate while driving and causes a collision. An evaluation of that person's behavior under the limited subjective standard would ask whether the defendant behaved as well as society should expect given the mental or emotional problem and the treatment received. Here the treatment was directed to identify and deal constructively with stress. Given the defendant's knowledge of stress management techniques, the defendant has not behaved as prudently as should be expected and would not escape liability under the limited subjective standard of care.

The use of a subjective standard of care for those mentally ill and walking wounded who sought treatment prior to the alleged tortious conduct avoids

93. *See, e.g.*, Oregon Health Services Commission, The 1991 Prioritization of Health Services.

94. *See* RESTATEMENT (SECOND) OF TORTS § 283(c) (1965). "If the actor is ill or otherwise physically disabled, the standard of conduct to which he must conform to avoid being negligent is that of a reasonable man under like disability." *Id.*

95. I am indebted to Grant Morris for suggesting this problem. For a review of the outcome research on stress management, see Lawrence J. Murphy, *Occupational Stress Management: A Review and Appraisal*, 57 J. OCCUP. MED. 1, 7 (1984). The strategies tested include biofeedback, meditation, muscle relaxation, and cognitive restructuring.

the criticism often leveled at a subjective standard of care. The argument that a uniform, predictable standard will evaporate and yield an infinite number of unworkable, individualized standards is not germane in these circumstances for three reasons: (1) the number of individuals who may invoke this standard is capped; (2) there is a disincentive to invoke the standard; and (3) there are pre-exisiting standards to measure the behavior of these individuals. The number of individuals who will have sought efficacious mental health care prior to the injury producing conduct is self limited. The floodgates of criticism remain closed. The rule is designed to encourage pre-accident treatment to reduce the risk of accidental injury. Only those who instituted efficacious treatment prior to the injury producing conduct could invoke this rule.

The floodgates concern is also ameliorated by a disincentive to invoke this modified standard. Invocation of this modified standard requires public admission of treatment for a mental or emotional problem and public disclosure of confidential therapist-patient communications. People labelled as mentally ill face a broad array of prejudices and immutable stereotypes.[96] Thus a motorist who is sued for negligent driving may be unwilling to engage in a public disclosure of this sort to defend the claim.[97] An attorney or physician who is sued for malpractice may be unwilling to risk the impact of that admission as a cost of defending the claim.

The concern that a modified standard presents insuperable problems of diagnosis and application of an individualized standard is also misplaced. Diagnosis of individuals who invoke the modified standard and assessment of their individual capacities is aided by the requirement that they have received treatment prior to the injury-producing conduct when no secondary gain was present. Again, these individuals are self-defined by the act of seeking mental health care prior to the tortious conduct at issue. Also, there is a professionally determined pre-accident baseline that may be used to measure the defendant's conduct.

The fear that people may seek treatment as a boiler plate defense against tort liability for unplanned future acts of negligence is unjustified. If the person seeking treatment has mental health problems that may benefit from treatment and actually complies with the prescribed treatment, a therapeutic result accrues regardless of the reason. This treatment may reduce the risk of injury and advance the accident reduction goal of tort law and therapeutic jurisprudence. If the person seeking treatment has no mental health problems that may benefit from treatment, a professionally determined baseline exists to defeat application of the limited subjective standard of care.

The fear that individuals may plan to commit a tort and use prior initiation of treatment as a defense is also unjustified for two reasons. First, the

96. Perlin, *supra* note 31.

97. There are certainly instances in which plaintiffs appear to have foregone claims for psychological injuries to avoid the disclosure of mental health records. *See, e.g.*, Martin v. Martelli, 554 N.Y.S.2d 787, 789 (1990) (holding that it would be imprudent to order release of all mental health records where there was no relation to accident, but allowing *in camera* inspection).

treatment may ameliorate the risk of the planned tortious conduct. Treatment may provide a therapeutic outlet for the thoughts or feelings that underlay the planned tort. Second, planned tortious conduct is an intentional tort, not a negligent tort. Although the defendant's mental or emotional problems are irrelevant to the standard of care in negligence actions, they are relevant in the case of intentional torts.[98] The defendant's mental or emotional problems are relevant to evaluate the defendant's intent to bring about a particular result or to be substantially certain that it will result. Thus, people planning tortious conduct who purposefully institute treatment to lay the groundwork for a later defense may be dissuaded from engaging in the planned tortious conduct and gain no legal advantage under the subjective standard.

An individualized standard factoring mental illness into the evaluation of conduct is generally permitted for plaintiffs on the issue of contributory negligence.[99] Contrary to the fears articulated about administering a civil insanity defense, the individualized standard for the contributory negligence of plaintiffs has not been reported to present insuperable problems. This may be relevant evidence that a limited subjective standard for mentally ill and walking wounded defendants who sought treatment prior to the tortious conduct would also not present insuperable problems.

IV. CONCLUSION

There is much to be said in favor of a limited subjective standard of care for the mentally ill and walking wounded who initiate treatment prior to the injury-producing conduct. Such a standard offers the potential to implement the accident reduction goal shared by tort law and therapeutic jurisprudence on a grand scale. The limited subjective standard has a limited downside risk since the floodgates are closed as of the date of the injury-producing conduct. And, the limited subjective standard of care has a built in baseline for measuring the defendant's conduct that should make its application easier and provide a disincentive for inappropriate use.

A limited subjective standard of care for the mentally ill and walking wounded who initiated treatment prior to the alleged tortious conduct may be convincing on therapeutic jurisprudence grounds and may deflect the arguments traditionally used to justify the objective standard of care. How-

98. In the case of torts such as battery that have a specific intent requirement, the existence of mental illness is a relevant consideration in the defendant's capacity to form that intent. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 135, at 1073 (5th ed. 1984).

99. RESTATEMENT (SECOND) OF TORTS § 464 (1965) ("Unless the actor is a child or insane person, the standard of conduct to which he must conform for his own protection is that of a reasonable person under like circumstances."); W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 32, at 178 n.39 (5th ed. 1984) ("The great majority of courts in the contributory negligence context apply a lower standard of care and consider the plaintiff's incapacity as only one of the 'circumstances' to be considered in judging the quality of his conduct."). *See also* Curran, *supra* note 30, at 63 (citing seven pre-RESTATEMENT (SECOND) OF TORTS cases, five of which apply a subjective standard for contributory negligence and two which do not).

ever, even if one is convinced by these arguments, there may be other reasons to challenge this proposal for a limited subjective standard of care. This proposal, which seeks to implement a modified standard of care to reduce the rate of injury, may be attacked as utilitarian. Utilitarian reasoning is vulnerable both because of its consequentalist approach and its unexplored empirical premises. The consequentalist concern is that utilitarianism is a result oriented approach focused on "maximized happiness"[100] that excludes consideration of other competing values.[101] Some critics have viewed therapeutic jurisprudence as a utilitarian-based reasoning that measures all legal decisions by their therapeutic consequences. Therapeutic jurisprudence has, however, moved quickly to counter this consequentialist criticism by recognizing that therapeutic consequences are not the only important concern in legal decisionmaking, but only one of a competing set of concerns.[102] Whether this pragmatic reformulation will result in a more careful balancing of interests must await future judgment.

A specific example of this consequentialist concern with therapeutic jurisprudence in the case of a therapeutically based standard of care for the mentally ill and walking wounded is the impact of that standard of care on another normative value, compensation. Even if a limited subjective standard of care encourages treatment, it denies compensation to plaintiffs injured through no fault of their own.[103] Thus, even if a limited subjective standard of care encourages a greater level of safety in some cases, that benefit must be balanced against denying compensation to some injured plaintiffs.

Compensation is, however, a relativist rather than an absolute concern of tort law. Not all injured plaintiffs are compensated by tort law. Plaintiffs seriously injured by conduct not thought to be in need of deterrence are not offered compensation by tort law. More specifically, the goal of compensation is subserved for plaintiffs injured by physically incapacitated defendants whose conduct is measured against those who are similarly disabled.

Thus, the fact that one consequence of the limited subjective standard of care for the mentally ill and the walking wounded will be to deny compensation to injured plaintiffs should not, by itself, result in a rejection of the rule. The choice necessitates a careful balancing of interests. This balancing should not occur in the abstract. Rather, it requires a precise analysis of the cost of injuries avoided against the cost of injuries not compensated. The

100. *See* JEREMY BENTHAM, AN INTRODUCTION TO THE PRINCIPLES OF MORALS AND LEGISLATION 2 (Athlone P. London 1970) (1789) (discussing the utilitarianism approach).

101. H.L.A. Hart, *Between Utility and Rights*, 79 COLUM. L. REV. 828, 828 (1979). Hart identifies two politically separate criticisms of utilitarianism. American conservatives criticize utilitarianism for its ignorance of "the moral importance of the *separateness* or *distinctiveness* of human persons." *Id.* *See* JOHN RAWLS, A THEORY OF JUSTICE 46-53 (1971) (discussing moral theory). American liberals criticize utilitarianism for its denial of the moral title to equal concern and respect. Hart, *supra* at 828. Leonard G. Ratner, *The Utilitarian Imperative: Autonomy, Reciprocity, and Revolution*, 12 HOFSTRA L. REV. 723, 749-55 (1984).

102. WEXLER & WINICK, *supra* note 1.

103. As noted earlier, the argument that any significant number of injuries occur without shared responsibility for the result may be a chimera. Yet, even if in a small number of cases, it is clear that in some instances this may occur. *See* Alexander & Szasz, *supra* note 58, and accompanying text.

posture of this question highlights another flaw in utilitarian based reasoning.

Utilitarian reasoning is vulnerable because it often assumes, without empirical examination, that a legal rule will result in a particular societal consequence. If a rule is based on a consequentialist rationale (i.e., that we should impose stiff criminal sentences on violent criminals to deter violent crime), empirical examination of the consequence of rule (i.e., the relationship between the severity of punishment and the rate of violent crime) is obligatory. Similarly, the argument for a therapeutic jurisprudence based on the limited subjective standard of care for mentally ill tort defendants turns on a series of empirically verifiable links. These empirically verifiable links include an assumption that tort law influences behavior, that mental or emotional problems play a causative role in tortious conduct, and that safe and effective treatment exists for mental or emotional problems. If any of these empirical premises is false, then therapeutic jurisprudence does not support the application of a limited subjective standard of care for mentally ill and walking wounded tort defendants.

The wisdom of this proposal thus returns to its original premise. Should tort law attempt to deter unsafe behavior? Perhaps it should not. Yet, if it should seek to do so effectively, tort law should not ignore the psychological reality of accident causation and the therapeutic potential of the standard of care.